MID-AMERICA ORTHOPEDIC & SPINE INSTITUTE, LLC
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

WITH MY CONSENT, AND BY SIGNING THIS FORM, I AM CONSENTING TO, MID-AMERICA ORTHOPEDIC & SPINE TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT ME TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. THIS PRACTICE RESERVES THE RIGHT TO REVISE THE NOTICE OF PRIVACY PRACTICES AT ANYTIME. A REVISED NOTICE OF PRIVACY PRACTICES MAY BE OBTAINED BY FORWARDING A WRITTEN REQUEST TO MID-AMERICA ORTHOPEDIC & SPINE PRIVACY OFFICER AT 1701 N. ELSON, KIRKSVILLE, MO. 63501.

WITH MY CONSENT, THIS CLINIC MAY CALL MY HOME OR OTHER DESIGNATED LOCATION AND LEAVE A MESSAGE ON VOICE MAIL OR IN PERSON IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TREATMENT, PAYMENT, AND OPERATIONS, SUCH AS APPOINTMENT REMINDERS, INSURANCE ITEMS AND ANY CALL PERTAINING TO MY CLINICAL CARE. WITH MY WRITTEN CONSENT, MY MEDICAL INFORMATION MAY ALSO BE RELEASED TO:

NAME:_____ RELATIONSHIP_____

THIS CLINIC MAY MAIL TO MY HOME OR OTHER DESIGNATED LOCATION ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TREATMENT, PAYMENTS AND GENERAL OPERATIONS. I HAVE THE RIGHT TO REQUEST THAT THIS CLINIC RESTRICTS HOW IT USES OR DISCLOSES MY PERSONAL HEALTH INFORMATION. HOWEVER, THE PRACTICE IS NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF IT DOES, IT IS BOUND BY THIS AGREEMENT.

I MAY REVOKE MY CONSENT IN WRITTING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURES IN RELIANCE UPON MY PRIOR CONSENT. IF I DO NOT SIGN THIS CONSENT, THIS CLINIC MAY DECLINE TO PROVIDE TREATMENT TO ME.

I ALSO ACKNOWLEDGE I HAVE RECEIVED AND BEEN GIVEN THE OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES OF THIS CLINIC.

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____
PATIENT'S NAME

DATE:_____